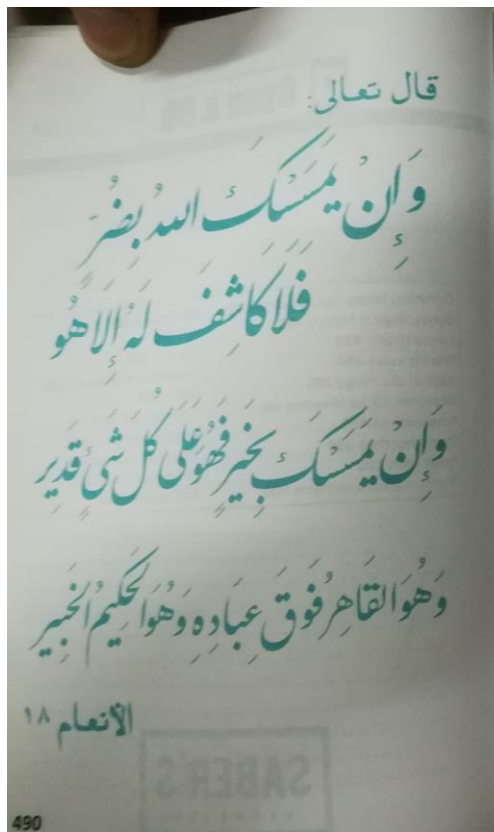


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1. Common menstrual terms and symptoms

Term/symptom	Definition	Comment
Menarche	Age when periods commence	Average age is 12 years in Western countries but is often later when girls are less well nourished
Primary amenorrhoea	No periods by the age of 16 years	Investigate
Secondary amenorrhoea	No periods for 3 months or more in a woman who previously menstruated regularly	Investigate only after 6 months; menstruation often resumes spontaneously. Exclude pregnancy
Oligo-menorrhoea	Periods occurring at intervals longer than 35 days and/or being particularly light	As above
Heavy menstrual bleeding (previously called menorrhagia)	Excessive blood loss	If affecting quality of life then investigate
Flooding	Episodes of very heavy menstrual blood loss	Embarrassing as may soak clothes, bedding or chairs. Passing clots simply indicates very heavy bleeding
Painful menstrual bleeding or dysmenorrhoea	Pain prior to or during the period	Usually felt in the lower abdomen, the back or the upper thighs
Menopause	The final spontaneous menstrual period. Only known for certain after no further bleeding for 1 year	Occurs on average at 51 years of age with a normal range 45-55 years
Peri-menopause	Time around the menopause when periods become erratic and menopausal symptoms (hot flushes and sweats) occur	Lasts 2-5 years on average
Postmenopausal bleeding	Spontaneous vaginal bleeding more than 1 year after the final menstrual period	Requires urgent investigation to exclude cancer in the genital tract

References: Macleod's clinical examination 12th ed. P 244

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2. Gynaecological history

- Let her tell the story.
- It is vital to appear confident, friendly & relaxed.
- Menstrual history:**
 - Date of last menstrual period (LMP: 1st day of bleeding) or menopause.
 - Was the last period normal?
 - Cycles:** number of days bleeding / number of days from day 1 of one period to day 1 of next period (e.g. 5/26).
 - Are they regular?
 - If heavy: are there clots or floods? How many pads/tampons are needed (an unreliable guide).
 - Are periods painful?
 - Any bleeding between periods, post-coitally or since the menopause?
 - Age of menarche?
- Obstetric history:**
 - How many children?
 - For each pregnancy: antenatal problem, delivery, gestation, outcomes: weight of babies, puerperium, terminations / miscarriages, at what stage, why? And terminations how?
- Symptoms:**
 - Pain:
 - Character**
 - Uterine pain may colicky & felt in the sacrum and groin.
 - Ovarian pain: felt in the iliac fossa and radiates down front of the thigh to the knees.
 - Ask about dyspareunia (painful intercourse).
 - Vaginal discharge:

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3. Menorrhagia

- Ask about amount, color, smell etc.
- When does she get it?
- Ask about bowel symptoms: IBS can cause pelvic pain.

3. Menorrhagia

- Menorrhagia (regular heavy periods) is common at the extremes of reproductive life.
- Cause:**
 - In girls:
 - Pregnancy.
 - Dysfunctional uterine bleeding (associated with anovulatory cycle).
 - Hypothyroidism.
 - Fibroids.
 - Premenopausal women.
 - Endometrial carcinoma.
 - General bleeding problem.
- Examination & investigations:**
 - Check Hb.
 - TFTs (for hypothyroidism).
 - Coagulation profile.
 - Pelvic ultrasound if pelvic pathology is suspected.
- Treatment:**
 - Reassurance helps.
 - Teenage menorrhagia generally settles without interference as cycle become ovulatory.
 - Antifibrinolytics**
 - e.g. tranexamic acid 1g/6-8hr po (for up to 4days).
 - R/Kapron 500mg

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4. Mefenamic acid 500 mg 8hr (after food) (Analgesic Anti-prostaglandin).
R/Ponstan forte 500mg 1x3
5. COC pills.
6. Danazol 100mg 8-24hrs PO (use only on special advice).
R/Danazol 200mg
7. Norethisterone 5-10mg / 8h.
R/Cidolut Nor 5mg 1x3

References:
Oxford - specialities: P 253.
General practice: P 42, 43.

4. Pruritis vulva D4T

Causes:

1. Any condition causing general pruritis.
2. Skin disease e.g. psoriasis, lichen planus.
3. Local:

- **Candida**
- Infestation (e.g. scabies, pubic lice, thread worms).
- Vulval dystrophy.

4. Symptoms may be psychogenic in origin.
5. Obesity & incontinence exacerbate symptoms.
- Post-menopausal atrophy does not cause itch.
- Always **exclude diabetes**.

Treatment:

1. Treat the cause if possible.
2. **Reassurance** is very important.
3. Advise her to **avoid nylon underwear, chemicals and soap** (use aqueous cream) and dry with hair dryer.
4. Short course of topical steroid.
R/Betaderm cream 1x2.

5. Anti-pruritic e.g. promethazine 25-50 mg /24 hrs
R/Phenergan susp. 5mg/5ml 1x2
R/Promantine amp. 25mg 1x2
Or any antihistaminic R/Claritine tab. 1x1
6. Avoid any topical preparation which may sensitize the skin).

References:

1. Oxford - specialities P 266.

5. Vaginal discharge D4T

- The most common causes in GP: are **Candida and Gardenella** (Bacterial vaginosis-BV).
- Less common: Trichomonas.

Candida:

- Class symptoms: pruritis.
- The **crudy white discharge** may be minimal.
- It is associated with **dysuria & dysparunia**.

Management:

A. Occasional symptoms

1. Topical imidazole e.g. clotrimazole pessary 500mg at height as a single dose.
R/Conestan supp. 10 mg 1x1x6.
2. Oral fluconazole 150mg as a single dose.
R/Flucoral 150 / Diflucan 150 (single dose).

B. Recurrent symptoms (> 3 years).

1. **Advice:** Avoid nylon underwear and perfumed soap.
2. **Exclude** risk factors e.g. Abs, DM, steroids.
3. Treat the partner concurrently.
4. **Treatment as above**
R/Conestan supp. 10 mg 1x1x6.
R/Flucoral 150 / Diflucan 150 (single dose).
5. **Followed by a maintenance regimen for 3-6 months:**
Imidazole pessary (e.g. Clotrimazole 500mg) weekly.
R/Conestan supp. 10 mg
Or Oral fluconazole 100 mg weekly (R/Flucoral 150)
Or Oral itraconazole 400mg monthly, at expected time of symptoms. (R/Arozole 100mg (4 caps) 4 each month)
6. If related to intercourse, insert a pessary after intercourse.

Bacterial vaginosis:

- Not considered to be sexually transmitted.
- Thin, grey discharge, with fishy smelling.

Treatment:

1. Metronidazole 100mg/12hr for 5 days R/Flagyl 1x2x5.
2. If symptoms are recurrent treat the partner concurrently.

References:

1. GP: P45, 46, 47.

6. Inter-menstrual (or post-coital) bleeding D4K

- Single episodes of non-menstrual bleeding are often innocent; the patient can usually be reassured and reviewed if the bleeding is persistent.

TIP: Persistent non-menstrual bleeding suggests a carcinoma until proven otherwise.

Causes:

1. Inter-menstrual:

- A mid-cycle fall in estrogen production.
- **Other causes:** vaginitis, cervicitis, IUD, hormonal contraception, cervical polyps, carcinoma, ectropion.

2. Post-coital:

- Cervical trauma, carcinoma, vaginitis, cervicitis.

Diagnosis: Ask about:

- The **duration and amount** of symptoms.
- The **amount and pattern** of bleeding e.g. post-coital, sporadic or regular.
- **Contraception.**
- **Exclude pregnancy.**

Management:

1. **Exclude chlamydia** (causes a blood stained discharge).
2. If the woman is on the COC and experienced breakthrough bleeding for more than 3 months, consider **changing her pill** to one with higher progestogen content.
3. If there is an IUD consider **removing** if symptoms persist for more than 3 months.
4. Spotting may occur for up to 6 months after IUD Insertion.
5. Cervical **erosions**. If symptomatic e.g. causing post-coital bleeding can be treated with a silver nitrate stick.

N.B. Women over 40 should always be referred.

Post-menopausal bleeding:

- It is any bleeding which occurs **1 year after the LMP**
- May be due to atrophic vaginitis.
- **N.B:** Always refer to exclude malignancy, unless. The bleeding is due to vaginitis which improves with treatment.

References:

1. GP: P39, 40.

7. Amenorrhea D&F

A. Primary amenorrhea:

- When the menarche has **not started by the age of 16 years**.

Causes:

1. Familial, structural (e.g. imperforate hymen), genetic (e.g. Turner's) and endocrine.
2. Look for 2ry sex characteristics.
3. Check wt to exclude anorexia nervosa.
4. Refer to gynecologist.

B. Secondary amenorrhea:

- (Always ask yourself "Could she be pregnant?").

Causes:

1. Hypothalamic-pituitary-ovarian causes:
e.g. emotions, exams, weight loss, excess prolactin, severe systemic disease e.g. renal failure.
2. Ovarian causes:
e.g. polycystic ovary syndrome, premature menopause (premature ovarian failure).
3. Pregnancy.

Diagnosis:

- History:** Ask about:
 - o Date of menarche.
 - o LMP.
 - o The normal cycle.
 - o Weight loss / eating disorder / stress.
 - o Drugs (e.g. COC).
 - o Galactorrhea (this occurs in hyper-prolactinaemia).
 - o Menopausal symptoms (e.g. premature ovarian failure).
 - o Hirsutism (this occurs in polycystic ovarian syndrome).

- o **General health** (symptoms of e.g. hypothyroidism, might be elicited).

Investigations:

- o Serum prolactin (Hyper-prolactinaemia??).
- o Serum FSH / LH (ñ in premature menopause).
- o Serum testosterone (slightly raised, along with LH and sometimes prolactin in polycystic ovarian syndrome).
- o TFTs.

8. Dysmenorrhea D&T

Painful periods (+ nausea promoting)

A. Primary dysmenorrhea (No pelvic pathology)

- Common in young girls.
- It usually appears **within 12 months of the menarche**.
- Crampy with ache in the back or groin.
- Worse during the first day or two.

Treatment:

1. Prostaglandins synthetase inhibitor:

- o Mefenamic acid 500mg /8hr po during menstruation.

R/Ponstan forte 1x3.

- o You may also prescribe R/Feldin flash قرص تحت اللسان عند النزول

2. Muscle antispasmodic:

R/Buscupan 10 2x4 قرصين كل 6 ساعات

B. 2ry dysmenorrhea:

- Associated with pelvic pathology e.g. endometriosis, PID. Chronic sepsis (e.g. Chlamydia infection), fibroids.

9. Pelvic pain S&T

Try to exclude the following:

1. Appendicitis.
2. Ectopic pregnancy: consider in all sexually active women with pelvic pain by: immediate pregnancy test & urgent pelvic ultrasound (a negative pregnancy test does not always exclude an ectopic pregnancy).
3. A ruptured ovarian cyst.
4. Acute PID.
5. Other pelvic pathology e.g. endometriosis which should be considered when recurrent episodes of pelvic pain fail to respond to antibiotic treatment.

10. Premenstrual syndrome D&T

- Worsening of mood or physical state pre-menstrually.

Symptoms:

- o **Commonest symptoms** patterns are tensions & irritability, depression, bloating & breast tenderness, headache.
- o Clumsiness, libido ↓, almost any symptom may feature.

Management:

A. Advice:

- Support and reassurance are vital. A menstrual diary, kept for at least 3 months, is useful.
- Exercise should be encouraged (ñ ed endorphin release may improve symptoms).
- A healthy well balanced diet should be encouraged in order to maintain steady blood glucose levels.

B. Prescribing:

1. NSAIDs are useful for pain symptoms & after improve mood & bleeding.

R/Ponstan forte 1x3 or R/Brufen 400 1x3

For mastalgia

2. Evening primrose oil (gamolenic acid) زيت ربة الربيع المسائية as a daily dose may be recommended. R/Primrose plus cap, 1000mg 1x1
CI: past history of seizures.
3. Bromocriptine 2.5mg/12hr po days 10-26 even if prolactin is normal.
R/Dopagon 2.5 1x2.
4. Danazol 100-200 mg/12h po for 7 days before menstruation.
5. Estrogens may be used.

References:

1. Oxford-specialities p254.
2. G.P. P 38, 39.

12. Menopause "Hints"

- Menopause is the **last menstrual period**.
- Problems are related to falling estrogen levels:
 1. **Menstrual irregularity**: as cycles become an ovulatory before stopping.
 2. Vasomotor disturbances: sweats, palpitations and flushes.
 3. **Atrophy** of estrogen dependent tissues (genitalia, breasts) and skin. Vaginal dryness can lead to vaginal and urinary infection, dyspareunia, traumatic bleeding, stress incontinence, and prolapse.
 4. **Osteoporosis**: predispose to fracture of femur neck, radius and vertebrae in later life.
- Is it menopause? Thyroid & psychiatric problems may present similarly so measure FSH if in doubt (very high in menopause).

References:

1. Oxford-specialities P256.

13. Polycystic ovarian syndrome (POS) D&R

- The syndrome consists of:
 - Androgens.
 - Oligo-ovulations.
 - Polycystic ovaries.
- The cause is unknown.
- Symptoms & features**
 - Obesity.
 - Virilisation with acne & hirsutism, male pattern baldness.
 - Irregular or absent periods.
 - Infertility (ovulation is sporadic or absent).
 - Darkened skin (acanthosis nigricans) on neck and skin flexures may reflect hyper-insulinaemia.
 - Insulin resistance (DM?)
 - HTN may also be a problem.
- Investigations:**
 - Blood results may show ↑ LH, ↑ LH / FSH ratio (e.g. days 5 & 8 of cycle), ↑ testosterone.
 - U/S shows characteristic ovaries.
 - Also check fasting blood sugar & serum cholesterol (POS patients have high rates of IHD, HTN & DM).
- Diagnosis:**
 - ↑ LH / FSH ratio: about 3:1 with ↑ testosterone + ↑ prolactin.
 - US scan showing 5 or more small follicles all < 5 mm along the peripheries of the ovary.
 - Laparoscopy shows enlarged ovaries.

Management:

A. Advice:

- Lose weight.
- Stop smoking.
- Encourage exercise, a healthy diet.

B. Prescribing:

- Treat hirsutism.
- Treat Acne.
- The COC regulates bleeding and prevents endometrial over stimulation.
- Metformin** will improve insulin sensitivity, menstrual disturbances and ovulatory function and is recommended. For those of BMI > 25 trying to conceive.
- Clomifene** will induce ovulation (by specialist).

References:

- Oxford-specialties P 252.
- GP: p 49, 50.

14. Infertility "Hints" D&R

Tip:

- Infertility is common, affecting 15% couples.
- 25% of cases of infertility remain unexplained.

The main causes of infertility are:

- Disorders of spermatogenesis.
- Ovulation disorders.
- Tubal / pelvic pathology.
- Others, e.g. endometriosis, sperm / mucus problems.

Diagnosis:

History:

- Confirm **regular intercourse** during the fertile period
 The fertile period is from day 8 to day 17 in a normal 28-day cycle.
- 90% of women of proven fertility will conceive (Be pregnant) within 12 months, investigations is therefore not usually undertaken until the couple have been attempting to conceive for 12 months or more.

- Semen analysis:**
 - A fresh warm specimen, produced after 48 hours of abstinence (No ejaculation), should be examined in the laboratory within 2 hrs of production.
 - Volume > 2 ml.
 - Count > 20 million / ml.
 - Normal morphology > 50%
- Confirmation of ovulation:** ovulation is suggested by:
 - Regular periods.
 - Pre-menstrual symptoms.
 - Ovulation pain

Source: GP: P 59, 60.

15. Symptoms of pregnancy

1. Symptoms and sign in the first 10 weeks.

Early symptoms are:

- Amenorrhea.
- Nausea & vomiting.
- Bladder irritability.
- Breast engorge, nipple enlarge (darken at 12 weeks).
- Montgomery's tubercles (sebaceous glands on nipples) become prominent.
- Vulval vascularity increases & Cervix softens & looks bluish. (4 weeks).
- At 6-10 weeks the uterine body is globular.
- Temperature rises (< 37.8 °C).

2. Headache, palpitations and fainting are all commoner in pregnancy. Sweating and feeling hot are also common due to dilated peripheral circulation.

- Management:** increase fluid intake & take showers.

3. Urinary frequency:

Due to pressure of the fetal head on the bladder in later pregnancy → **exclude UTI.**

4. Abdominal pain.

5. Breathlessness.

6. Constipation.

- Tends to occur as gut motility decreases.
- Adequate oral fluids and a high fiber diet helps.
- Avoid stimulant laxatives:** they increase uterine activity in some women.
- Increased venous dispensability and pelvic congestion predispose to hemorrhoids → if they prolapse → rest the mother head down, apply ice packs and replace them).

7. Reflux oesophagitis and heat burn:

- Cigarettes and spices should be avoided.
- Small meals.
- Antacids may be used.
- Use more pillows & semi-recumbent position.

8. 3rd trimester backache:

- Pain tends to be worsening at night.
- A firm mattress, flat shoes, standing with back straight all help.

9. Carpal tunnel syndrome:

- Advise **wrist splints** until delivery cures the problems.

10. Itch / Itchy rashes:

- May be due to usual causes as liver failure.
- Or due to pruritic eruption of pregnancy (PEP = prurigo of pregnancy) → an intensely, itchy popular (plaque rash on the abdomen and limbs.
- Give any weak topical steroid **R/Elica cream 1x2**

11. Ankle oedema:

- Very common, almost normal manifestation of pregnancy.
- Exclude pre-eclampsia (check BP for HTN, check urine for proteinuria, check for more generalized oedema).
- Advise the patient to avoid long periods of standing if oedema becomes uncomfortable, advise her to sit with the ankle above the level of the hips when resting and to **wear support stocking or tights.**

12. Leg cramps:

- 33% get cramp, the latter half of pregnancy.
- Severe in 5%, at night.
- Raising the foot of the bed by 20cm will help.

13. Nausea and vomiting:

- Vomiting in pregnancy can be extremely debilitating and the patient often requires considerable support and reassurance.
- It may start by 4 weeks and **resolves by 14-16 weeks.**
- Encourage fluids (carbonated drinks can be helpful) and frequent, small, plain meals.

Treatment: R/Vomistop 1x3

- Consider admission if vomiting is prolonged or there is dehydration.

References:

1. Oxford specialties p 17.
2. GP: P28, 29.

16. labour

- It is the process of birth in response to uterine contraction the lower segment stretches and thins, the cervix dilates, the birth canal is formed & the baby descends through the pelvis.

1. Uterine contraction

Contracted & retracted so the uterine capacity is progressively reduced and the thickness of the uterine wall increased.

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2. Cervical effacement

Retraction of the upper segment causes stretch and thinning of the lower segment & cause effacement and cervix lower ut. Segment. **Effacement** يعني ان cervix يصبح جزءاً من lower ut. Segment.

3. "Show" and formation of forwaters

Show: is slight bleeding and mucus plug.

Labour**■ Stages:**

First: start to full dilatation of the cervix.

Second: from full dilatation to birth of the baby.

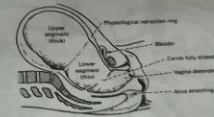
Third: from birth of the baby to delivery of placenta (afterbirth).

■ At the beginning of labour:

- The fetus is descending during first and 2nd stages.
- The birth canal is formed.
- The bladder is pulled above & the bowel compressed.

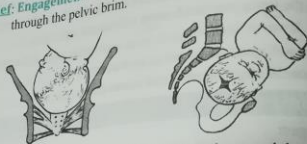
**■ Mechanism of labour: "In brief".**

BIRTH CANAL AT BEGINNING OF SECOND STAGE



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Def: Engagement: is the descent of the presenting diameters through the pelvic brim.



1. After some changes descent of the head continues and the occiput reaches the pelvic floor



2. Internal rotation occurs & the head is now occipito anterior (OA).



3. The occiput is now below the symphysis & extension the occiput is delivered.



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4. Increasing extension round the pubis delivers the bregma, brow and face.



Delivery of head



Delivery of head

5. The head now: rotates to the natural position "Restitution".



Restitution



Restitution

6. External rotation

External Rotation



External Rotation

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7. The posterior shoulder is born then the rest of the body follows easily.

Diagnosis of labour:

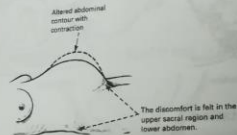
True labour

- Regular contractions.
- "Show".
- Progressive dilatations and effacement of cervix.

Labour is recognized by:

1. Palpable uterine contractions:

- Regular in frequency.
- Intermittent in character.
- The interval between contractions is **10 minutes or less and each contraction may last half a minute or longer**
- The uterus becomes firm and rises altering the abdominal contour.

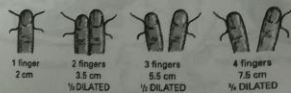


2. "Show":

A little blood and mucus discharged from the vagina.

3. Dilatation of the cervix & formation of forewater.

Cx dilatation is gauged by vaginal examination and is expressed in the diameter across the Cx.



Points to be noted:

1. Degree of **dilatation** and effacement of the Cx.
2. Presence or absence of forewaters.
3. State of liquor if any (clear? meconium stained).
4. Position of the presenting part. Determined by palpating the suture lines and fontanelles in relation to pelvic diameters.
5. Level of the presenting part. This is judged by its relationship to the brim or ischial spines.
 - The diagram shows a well flexed head in the LOL position which is almost engaged (the sub-occipito-bregmatic diameter is just above the brim, the CX is about 3 fingers, dilated and the forewaters are present).
 - Descent of presenting part is recognized by abdominal palpation or vaginal examination.

The 1st stage:

- In primigravida lasts up to 12hrs & sometimes longer.
- In parous woman: usually 4-8 hours.

The 2nd stage:

- In primigravida: lasts about 1 hour.
- In parous woman: is much shorter.
- It is recognized by change in the characters of the contractions which become more powerful and expulsive with a desire to bear down.
- The diaphragm is fixed; the patient holds her breath and the abdominal muscles contract.
- Sometimes the feels nauseated and may vomit.

Management of labour:

1. General considerations:

- The aim should be to provide the mother with a relaxed friendly atmosphere.
- The presence of husband & relatives.
- The labour room should have:
 - CD player/cassette or TV. For entertainment and distraction.
 - Bed.
 - Bathroom & shower.

2. Care of the mother:

- Should not be left alone. Supportive midwife.
- Minimal perineal shaving may be done in case of episiotomy is required.
- Access to bath or shower should be available.
- Bowel should be evacuated.

3. Pulse rate, BP & urinary output are measured regularly & if ketosis or dehydration develops this is treated by intravenous fluids.

4. Diet is withheld as delayed gastric emptying leads to the danger of inhalation of stomach contents.

5. Analgesia by:

- Inhalation**
Entonox in a 50:50 mixture of O₂ & nitrous oxide.
- TENS** (trans-cutaneous electrical nerve stimulation electrodes on the backs on certain dermatomes).
- Narcotic drugs.**
 - Pethidine 100-200 mg. by IM
 - Morphine 10-20 mg. by IM
 - Or diamorphine 5-10 mg.

Diamorphine is preferred now d.t its better analgesic and anxiolytic effect.

+ Antiemetic.

N.B. if there is any evidence of respiratory depression of the baby this can be encountered by the IV naloxone.

d. Continuous epidural anaesthesia.

- Local anaesthetic (0.25% or 5% bupivacine) is instilled at 3-4 hrs intervals through a catheter inserted into the epidural space.
- This gives the patient complete freedom from pain.

References

1. OB. illustrated P224 - 237.

16. Contraception

Types of contraception:

1. Hormonal contraception.
2. IUCD.
3. Vaginal diaphragm.
4. Condom.
5. The rhythm method (safe period).
6. Coitus interruptus.
7. Vasectomy.
8. Tubal ligation, tubal occlusion.

1. Hormonal contraception

Has 4 forms.

1. Combined (estrogen / progestogen) pills. (COC)
2. Progestogen only pills. (POP)
3. Progestogen-only injections or implant.
4. Progestogen-intrauterine system.

A. Combined pills: R/Microcept

- Taken **daily for 21 days**.
- & a withdrawal bleed will normally occur in the pill free days.

Mode of action:

- Prevents ovulation & ↓ FSH & -- follicular development & no LH peak (d.t estrogen).
- ↓ Endometrial development & absence of a corpus luteum will ↓ implantation (d.t both).
- change in cx mucus → ↓ chance of sperm penetration.

■ Major side effects:

1. Thromboembolism.
2. Due to alteration in clotting factors.
3. Myocardial infarction and stroke.
 - Especially women over 35ys who smoke.
 - Pills ↓ HDL2 who is inversely proportional to the risk of ht. dse.
4. Hypertension.
 - Due to fluid retention & ↑ secretion of angiotensin.

■ Minor side-effects:

- Oestrogen
 - Break through bleeding.
 - Nausea.
- Oestrogen & progestogen
 - Weight gain.
 - Post-pills amenorrhoea.
- Progestogens
 - Acne.
 - Depression.
 - Loss of libido.
 - Insulin resistance (DM??).
- Painful breasts.
- Headaches.

■ Contra-indications.

- a. Absolute.
 - CVD.
 - Liver dse.
 - Breast cancer.
- a. Relative.
 - Smoking.
 - HTN.
 - Obesity.
 - Migraine.
 - Special precautions.
 - DM.
 - Surgical operations.
 - Over 35 ys.

■ Cancer & the pill

- Risk of cervical cancer.
- Risk of breast cancer.
- Risk of endometrial & ovarian cancers.

■ Failure of the pill.

1. If a pill is missed, it should be taken when remembered and the next pill is taken at the usual time.
2. Vomiting or diarrhea may impair absorption.
3. Anti-convulsants & rifampicin ↑ hepatic enzymes activity & ↑ Excretion.
4. Pencillins and Cephalosporins ↑ bowel excretion of the pills d.t. inhibition of gut bacteria.

B. Progestogen only pills R/Microlut

1. Oral: called "mini pill".

- Taken daily without break.
- The main advantage is the absence of the menstrual cycle.
- Increased pregnancy rate than combined pills.

2. Parental:

a. Injections:

- Taken every 3 months or 2 months according to type.
- The main side effect is menstrual irregularity and amenorrhea.
- May be some delay in the return of fertility following discontinuation, of the treatment.
- Pregnancy is unlikely for 8 to 9 months after the last injection.

b. Implant:

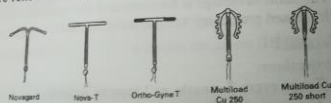
- **Implanon** is a single flexible rod containing 68mg of etonogestrel is placed sub-dermally and is highly effective for up to 3 years.

3. Intrauterine system:

- **Levonorgestrel** may be released directly into the uterine cavity from a T-shaped plastic intra-uterine device which contains a reservoir releasing 20 microgram per 24 hrs.
- Return of fertility after removal is speedy.
- It has an advantage over other IUDs by reducing blood loss.
- The device is effective for 3 years.

2. Intra-uterine contraceptive device (IUCD)

- It is a small plastic carrier usually in T shape or similar design.
- It is on the vertical stem of which is wound some **Copper wire** and may have copper bands on the transverse arms.
- It is sufficiently flexible to be drawn into an introducer for insertion into the uterine cavity, because of the gradual absorption of the copper the IUCDs are renewed every 3 to 5 years.

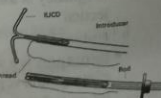


■ Mode of action:

- Interferes with implantation.
- The presence of copper enhances F.B reaction in the endometrium.

■ Principles of insertion of IUCDs:

1. The IUCD is first of all folded and folded into a plastic tube called the introducer.



2. The introducer is then inserted into the uterus.



3. The IUCD is forced out of the inserter by a rod.
4. And takes up its position in the uterus.

■ Technique of insertion:

1. The cx is exposed, swabbed and grasped with a tenaculum forceps.
2. The introducer is inserted and the IUCD expelled into the cavity.
3. The thread is then cut, leaving about 5cm in the vagina.



■ Complications of IUCD

1. ↑ ed menstrual loss.
2. PID.
3. Pregnancy: with ↑ ed risk of being ectopic.
4. Uterine perforation during insertion.
5. **Expulsion**: usually in the first 6m.
 - It is most likely to occur during menstruation and may be unnoticed by the patient.

■ CI:

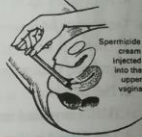
- PID.
- Menorrhagia.
- Severe dysmenorrhea.
- Hx of previous ectopic pregnancy.

3. Vaginal diaphragm (CAP)

- Rubber diaphragm smeared with spermicidal cream.
- Must not be removed until 6 hrs after intercourse & if intercourse is repeated in the period, more cream must first be injected with an applicator.

**4. Vaginal spermicide****Forms:**

Creams, pessaries, gels or aerosols.

**5. The rhythm method (safe period)**

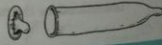
Usually coitus must be avoided from the 9th to the 15th and a 24hrs safety margin at either end increases the avoidance period from the 8th to the 17th inclusive.

6. Coitus interruptus:

This means withdrawal of the penis just before ejaculation.

7. Condom

Effective if used correctly.

**8. Vasectomy****9. Tubal ligation, tubal occlusion**

All figures of this chapter are from Obstetrics Illustrated

17. Drugs & pregnancy**A. Drugs that may be safe**

- Penicillins.
- Cephalosporins.
- Sulphonamides.
- Trimethoprim (Septazole-Septin).
- Nitrofurantoin (R/Uvamin).
- Paracetamol (with caution).

B. Avoid these drugs

- Tetracyclines.
- Streptomycin.
- Ciprofloxacin and all Quinolones.
- Erythromycin and all Macrolides.
- Chloramphenicol.
- Quinon.
- Vit A

C. Caution

- Aminoglycosides.
- Nalidixic acid.
- Vancomycin.
- Metronidazole.

18. Drugs and lactation**A. Safe**

- Tetracyclines.
- Cimetidine.
- Ergots.
- Nicotine (smoking).
- Thiouracil.
- Iodides.
- Cyclosporine.
- Anti-neoplastic agents.

B. Drugs that should be avoided or given with great caution

- Aspirin.
- Birth control pills.
- Atropine.
- Estrogens.
- Metronidazole.
- Sulfasalazine.
- Narcotics.

19. Drugs that may be safe but should be given with caution

- Paracetamol.
- Acyclovir.
- Antithyroid.
- Antibiotics (not tetracyclines).
- Antihistamines.
- Anti-hypertensives.
- Diuretics.
- Digoxin.
- Indomethacin.
- Quinolones.
- Ms relaxants.
- Theophylline.
- Vitamins.
- Warfarin.
- Prednisolone.

Put in your Mind

1. Date of 1st menstrual period (LMP) = 1st day of bleeding.
2. Ovarian pain is felt in the iliac fossa and radiates down front of the thigh to the knees.
3. Menorrhagia is regular heavy periods.
4. Hypothyroidism may be a cause of pruritis vulva.
5. Candida is a common cause of pruritis vulva.
6. Exclude DM in case of pruritis vulva.
7. Persistent non-menstrual bleeding suggests a carcinoma until proven otherwise.
8. Exclude pregnancy in case of inter-menstrual bleeding.
9. Chlamydia causes blood stained discharge.
10. Women over 40ys with inter-menstrual bleeding should be always referred.
11. Always refer post-menopausal bleeding to exclude malignancy.
12. Primary amenorrhea when the menarche has not started by the age of 16 ys.
13. Always exclude pregnancy in case of secondary amenorrhea.
14. Hypothyroidism is a cause of 2ry amenorrhea.
15. Check TFTs, prolactin, FSH / LH in 2ry amenorrhea.
16. Dysmenorrhea is painful periods (with or without N & V).

17. Premenstrual bleeding:

Tension, irritability, depression, bloating, breast tenderness, headache, clumsiness, ↓ libido.

18. Some of early symptoms of pregnancy are:

Amenorrhea, N & V, bladder irritability, breast engorge, nipple enlarge, Montgomery's tubercles on nipples.

19. Thyroid and psychiatric problems may present similar to menopause so check FSH if in doubt (very high in menopause > 20 U/L).

Test yourself

1. Trade name of COC is POP is
2. Def. of engagement?
3. Mention types of contraception (7)?
4. List in brief treatment of candida causing vaginal discharge?
5. Complications of IUD?
6. N&V of pregnancy may start by weeks and resolves by weeks
7. POP is called
8. Def. of LMP?
9. Def. of primary amenorrhea?
10. Avoid the following in pregnancy
11. Causes of menorrhagia?
12. The common causes in GP?
13. Character of ovarian pain?
14. Structural cause of primary amenorrhea?
15. Common symptoms of pre-menstrual syndrome?
16. 5 early symptoms of pregnancy?
17. Treatment of dysmenorrhea?
18. Def. of menorrhagia?
19. Treatment of pruritis?
20. The main causes of infertility?
21. Def. of menopause?
22. Causes of pelvic pain?
23. Def. of dyspareunia?
24. POS consists of
25. Local causes of pruritis?
26. Treat the following problems of pregnancy
Nausea and vomiting
Itchy rashes

Answers

1. Microcept, Microlut
2. The descent of the presenting diameter through the pelvic brim
3. Hormonal contraception.
IUCD.
Vaginal diaphragm.
Condom.
The rhythm method (safe period).
Coitus interruptus.
Vasectomy.
Tubal ligation, tubal occlusion.
4. R/Conestan supp. 10mg 1x16
R/Flucoral 150 (single dose)
Avoid nylon underwear and perfumed soap
5. ↑ ed menstrual loss.
PID.
Pregnancy: with ↑ ed risk of being ectopic.
Uterine perforation during insertion.
Expulsion
6. 4, 14-16
7. Minipill
8. 1st day of bleeding
9. When the menarche has not started by the age of 16 years
10. Quinolones, Macrolides, vit A, tetracyclines
11. IUD
Pelvic infection
Pregnancy
hypothyroidism
12. Candida and gardenella
13. Felt in the iliac fossa and radiates down front the knees
14. Imperforate hymen
15. Tension and irritability
Depression
Bloating
Breast tenderness
Headache
16. Amenorrhea
N&V
Bladder irritability
Breast engorgement
Montgomery tubercles
17. R/Ponstan forte 1x3
Or R/Feldin flash (when needed)
R/Buscupan 10 2x4
18. Regular heavy periods
19. R/Betaderm 1x2
R/Claritine 1x1
20. Disorders of spermatogenesis
Ovulation disorders
Tubal/pelvic pathology
Others e.g. endometriosis, sperm/mucus problems
21. The last menstrual period
22. Ectopic pregnancy
Rupture ovarian cyst
Acute PID
Appendicitis
23. Painful intercourse
24. Androgens
Oligo-ovulations
Polycystic ovaries
25. Candida
Infestations
Vulval dystrophy
26. R/Vomistop 1x3
R/Elica cream 1x2

